Service Log - Case Management
3 Yr. Special Education Reevaluation T1018 TM

-Pink paper form-

Student: _____ **Diagnosis:** _____
Last Name First Name

SS# _____ **School District:** _____

Date of Birth: _____ **Supervisory Union:** _____
mm/dd/yyyy

All header information must be completed:
- Student Name
- Social Security Number (SS#)
- Date of Birth
- Diagnosis Code
- School District
- Supervisory Union

Check appropriate box to indicate type of eval:

- ☐ Initial Evaluation (cannot be reimbursed)
- ☐ Student's First Eval but was on IFSP
- ☐ 3 Year Reevaluation
- ☐ Completed Form 8 (cannot be reimbursed)

The type of Eval must be checked. Initial Evaluations and Form 8's are not reimburesable

Beginning Date of Evaluation Process: _____
mm/dd/yyyy

Evaluation Process Completed: _____
mm/dd/yyyy

Evaluation determination meeting: _____
mm/dd/yyyy

_____
mm/dd/yyyy

The beginning date and completion date of the evaluation process must be completed

The evaluation meeting date is the date used as the to and from date when submitting the claim to EDS

Please check all activities completed during the evaluation process (at least 6 activities must be performed in order for the claim to be billable to Medicaid)

Check	Activity
	1. Reviewed student's records prior to evaluation planning meeting
	2. Requested input from service providers and team members to begin the evaluation process
	3. Meeting to plan evaluation
	4. Arrange and schedule testing/assessment
	5. Assessment/conduct testing
	6. Gathered information from other provide[illegible]acher, mental health counselor, principal, nurse, gu[illegible] student's performance
	7. Visit to home, childcare, etc…
	8. Classroom observation
	9. Interpreted information and testing results from other providers
	10. Eligibility determination meeting and eligibility determination
☐	Eligible
☐	Not Eligible
	11. Interpretation and compilation of information to develop the Evaluation Report

The case manager needs to indicate with a check or an "X" the activities that they completed as part of the evaluation process. A minimum of 6 activities must be performed in order for the evaluation to be billable to Medicaid

The eligibility determination must be indicated by placing a check or "X" next to eligible or not eligible

Case Manager's Signature _____ **Date:** _____

Case Manager's Printed Name: _____

The case manager needs to sign and date the form and print their name

Payment Information

Submit Date: _____ RA Date: _____

The Medicaid clerk is able to update the header information, the case manager's printed name and the payment information. All other information **must** be completed by the case manager